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| **Interview ID Code**  **(Interview number; country) and date of interview** | PROF1 UK  April 2018 |
| Job role | Egg donor coordinator, intermediary |
| Organisation | Egg donation agency |
| Public/Private/Both | Private |
| Interviewer initials | KC |
| **Interview summary** | Egg donation agency that recruits egg donors and matches them with recipients against a fee (annual membership) paid by recipients.  Recruitment occurred through online forums; P1 would be active on forums and reach out to women discussing how to become a donor and recruit them to the agency; before recruitment moved online, P1 would travel across the country to exhibitions and events such as mother and baby events, health events.  They prioritized donors age followed by ethnicity; some judgements done on ‘how they looked’ in informal way. BMI was important  P1 was the contact for donors and on call for any support and information needed; mentions how many relationships became friendships  In regards to donor matching, they worked on the philosophy of one donor to one couple per cycle; but one donor could be matched with another couple on next donation round.  Challenges after recruitment: not finding a match to donor, donors not adhering to appointments, needing a lot of support whereas others were more independent  All donors gets £750; if expenses higher (travel from Scotland to London), more could be paid. Convinced their donors don’t do it for the money.  Risk of overstimulation are mentioned and infection but described as tiny risks; talks about social risks of telling relatives about wanting to be donors and family not agreeing .  Recipients get non-identifying information about the donor, incl seeing baby-pictures.  Donors are told how many eggs were retrieved, either by clinics or they can ask agency and agency will inquire on their behalf. All donors go through counselling. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF2 UK**  **April 2018** |
| Job role | Counsellor |
| Organisation | Fertility clinic |
| Public/Private/Both | Private (also has experience of the NHS) |
| Interviewer initials | NH |
| **Interview summary** | Large private (standalone) fertility clinic in UK major city. Mainly provides implications counselling by phone/Skype in the evenings  In private sector not many people take up counselling – and then its just the implications stuff. There is less in terms of patient support.  Regards lack of NHS egg donation as discriminatory – a decision of the local funding group.  Clinic use agencies to recruit donors and the clinic has a donation team – working with the agency who advocate for donors and protect their interests.  Counsellor checks on donor perspective on contact with offspring. Vetting of this and any issue referred to clinic and their motivation is questioned.  Matched by clinic – by doctors. They have photo of recipient and donor (passport).  Some donors are interested in where eggs are going. – are the recipients ok? Sometimes donors want more info e.g. about baby – this is regarded as problematic mental health issue.  Few donors mention money – they are asked about it – and if they mention anything probes to see if there is financial motivation (which they disapprove of). Show too much interest in getting paid then would not use that donor again. (If they have financial motivation they might not ‘deliver’ on the other obligations e.g contact). However, she suggests could increase compensation.  Sometimes gets panic calls from people rejected and have been told e.g. Hep B  Then later in interview says does not think there are any risks.  Need to improve HFEA website. Should be a standard check list of questions to be used by counsellors.  Encourages donors to give pen portraits. Recipients get this before treatment.  Also thinks recipients need more info. About future info release.  Is concerned that no one is sure how many times donors have donated and also affect on fertility – need more research. Donors do not take about the long term impacts.  The counsellor is the last stop for the donor – been through medical screening, etc. – and her letter is the green light.  Reports that some donors who have donated elsewhere say they have not had any counselling – which worries her. Her clinic have very good protocol. |

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| **Interview ID Code (Interview number; country)**  **and date of interview** | **PROF3 UK**  **May 2018** |
| Job role | Medical Director |
| Organisation | Large clinic group in UK |
| Public/Private/Both | Private (though group deliver NHS contracts) |
| Interviewer initials | NH |
| **Interview summary** | Large clinical group in the UK providing in house egg donation.  Recruit own donors. Recruit mainly by radio adverts, social media, word of mouth and own website.  Does egg donation, egg sharing, known donors and intra-partner donations and surrogacy.  Donors are screened and then meet the donation nursing team, have ultrasound and then go on to implications counselling. Same process for known donors who are about 10% of donors.  Do not use egg banks – not found one that meets the HFEA criteria.  Mainly do fresh – in which case in group shortages are handled by moving the recipients between clinics.  Shortage of minority ethnic donors – do targeting recruitment but not really worked.  Profile of women varies according to region. In some more students, others women with own children, or a mix. Seems to relate to where clinic is located – city centre or out of town.  Match on hair and eye color, skin tone, height weight, ethnic group – though that’s not essential. Offer pen portraits and good will message to recipients.  Compensation - would probably go higher than 750- more like 2000 Euros that they get in Europe– it’s a lot to go through.  Donors have a lot of info e.g. about injections etc. there is a dedicated donation team who do a lot of work with them at the donation appointment.  They get lots of repeats – that go up to 6 and would go beyond if allowed.  There are potential emotional risks for those without children and for egg sharers.  Need clearer guidance from HFEA on screening – code isn’t clear and its out of date. Too much left for interpretation by clinics.  Rejects are spoken with and referred to appropriate services.  Very few drop out at the end. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF4 UK**  **July 2018** |
| Interviewer initials | KC |
| Job role | Egg donor co-ordinator |
| Organisation | Large clinical group |
| Public/Private/Both | Both |
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| **Interview summary** | Clinic is member of a large clinical group with clinics all over the country  There is no shortage of donors and she sees the demand increasing  Egg sharing is a popular scheme in their clinic  Option for recipient to have shared donor (max. 2 recipients share), or a sole donor (higher costs, remaining eggs are frozen)  Repeat donors come not because of the money, but because of the positive outcome and because they have enjoyed the process  Donors recruited through social media; campaign in city centre. No recruitment help sought from agencies  Before donors get counselling, physical eligibility is checked to make sure not to waste time. With anonymity law fewer donors came forward; recruiting minority ethnic donors is a big challenge  ID-release, known, egg share. No freeze-and-share. Known donation: happens, majority of known donors are from white couples  Of the ID-release donors, they are either in their early 20s, students, no kids, or have had their kids and are in early 30s  Support offered to women who come with intention to be donors and turned away for low egg reserve, genetic reasons, etc. Follow up the donor – they can contact if they need anything  Matching done by characteristic sheet; recipient can request blood type matching too  Main motivation for the egg shares is the significant discount on their cycles; main motivation for ‘altruistic donors’ the £750, but also passionate about donating, knowing someone who struggled with fertility. Considers the compensation not enough – ‘they ought to get thousands’.  Thinks the UK got it about right in policy terms, considers it quite heavily regulated |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF5 UK**  **August 2018** |
| Job role | Medical director |
| Organization | Fertility clinic |
| Public/Private/Both | Both |
| Interviewer initials | NH |
| **Interview summary** | Large clinical group in the UK, multiple clinics  Donors recruited via social media adds, in shopping centres – offering free health checks, reproductive health checks.  Declined the help of agencies, they are happy with recruitment results in surrounding area;  Ideal donor between 20-30, but until 35 possible, own family completed as proven fertility – also this is something they see recipients preferring; healthy, BMI below 35  If recipients bring in their own known donor, they stretch the age limit  Demography of donors has changed: more younger women, 22-25 years old, without families on their own, coming forward  At time of interview more donors than recipients.  Recipients and donors describe their physical characteristics; donor can exclude potential recipients, but haven’t done in the past: matching by physical characteristics  They have people with previous IVF treatment coming offering themselves as donors  Egg sharing is going on; they saw a drop in egg sharing with the raise in NHS funding for IVF cycles; they limit egg sharing to EP who provide a minimum of 8 eggs, and prefer not allow egg sharers with severe male sperm factors to not risk the creation of fewer embryos  Describes the potential of discomfort and physical risk; risk to fertility in relation to young childless women  £750; considers it too little and mismatched in comparison to egg sharing ‘compensation’ (£3k) Donors should be paid more.  Fertility information should be improved in the UK |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF6 UK**  **August 2018** |
| Job role | Co-ordinator of service for group of clinics. HR marketing, advertising |
| Organisation | Clinic group UK wide |
| Public/Private/Both | Both: private but also delivers NHS contracts |
| Interviewer initials | NH |
| **Interview summary** | Large national fertility group. This person has overview of how the service is running.  Tries to slimline and smooth the process for donors. Not present them with scary information.  Currently have more donors than waiting list. Thinks this is due to word of mouth and treating them well. Being flexible about appointments. Done some advertising.  Compensation has really helped to increased donor numbers.  Also talks about advertising being helpful. Only 1 Asian donor  Loves altruism – some give money to charity – its not a lot of money for what we ask them to do.  Prefer fresh cycles. Do seem to share eggs within the clinical group – at 6 or 8 eggs and split them over fresh/frozen . freezing convenient for recipients.  Conversion rate enquiries to donors of 10%  Thinks agencies charge too much money to recipients.  Donors paid at collection irrespective of outcome. If pull out sooner are paid for each day they came. £35  Some recipients ask for very specific things – e.g. education, religion. Have to be honest that they might have a wait.  Donors are monitored for OHSS regularly and drugs amended. At appointments go through all the risks. Donors are ‘well looked after’. Avoid overstimulation.  Policy reflections - maybe allow more info about donor to recip.  Increase payment – recognizing what they have to go through maybe just to £1000. Don’t want to go down the US way – not be an incentive, just a recognition.  Not happy to work with for profit egg agencies. Would like NGDT to have more active role.  Keep separate appointments for donors and recipients - don’t allow contact, getting difficult with facebook. Recipients often want more info. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF7 UK**  **October 2018** |
| Job role | Senior fertility counsellor; leading patient support team |
| Organisation | Fertility clinic |
| Public/Private/Both | Private with NHS contracts |
| Interviewer initials | NH |
| **Interview summary** | Large private chain of fertility clinics, currently several across the UK with more opening in the near future; all clinics are owned by one person.  All their counselling services are linked, so if a patient in clinic A can’t get a counsellor, they can get support from clinic B via phone. They provide private and NHS treatment, the majority are private patients.  Recruit donors through social media; at universities and advertisement in train stations. Talks about targeted add by Google.  Describes a rigorous screening for physical health, mental health, the right attitude to their eggs, own expectations of motherhood and that donors can withdraw consent at any time. Takes 3-4 months from initial contact.  High number of co-parenting arrangements; in screening they are treated as donors; lesbian/bi intra-couple arrangements are NOT treated as donation;  Freeze-and-share; egg-sharing; known donors.  Offer unlimited counselling support for donors and partner – over their lifespan (donors can come back anytime if they need ‘a chat’ or counselling)  Describes how patients can browse the list of donors – concludes that it works.  The recipients’ payment is for the admin fee, not the eggs.  Altruistic motivation; EP are blood donors, and many consider surrogacy in the future; a lot of women know of someone having undergone fertility treatment  They provide donors with information about infertility and the impact of infertility so they come to appreciate their egg provision as a gift; outcome should be having enabled someone to try, not the outcome of a guaranteed baby  Offer egg-sharing but advises that their bar is high; initially the clinic promoted egg-sharing; but now they refrain from promoting unless asked by the patient for the option.  Donors are informed about risk of OHSS, and to make sure to attend the follow-up appointment, and take up any future counselling if they need if only to discuss any thoughts or worries (mentally, and physically).  £750; some donors didn’t want it and wanted them to give it to charity.  Known donation can be a challenge because in their experience, in most known arrangements something has gone wrong or become difficult during the arrangement.  Eggs are allocated in a batch of 5. Donors can consent to the number of recipients. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF8 UK**  **October 2018** |
| Job role | Consultant |
| Organisation | Roles in NHS and private IVF clinics |
| Public/Private/Both | Both, most ED in private |
| Interviewer initials | NH |
| **Interview summary** | See above. Regrets lack of NHS funding for ED Tx e.g. premature ovarian failure.  Private clinic works with donor recruitment agency. Tried recruitment themselves but not very successful. Like the agency as they look after their donors, have them all over country, have minority ethnic and are good at matching.  Thinks Social egg freezing will make big difference – as they may be inclined to donate them if they don’t use them.  Thinks £750 very important – in changing clinic behavior to try and attract donors but also vitrification as this removes need for synchronization.  They toyed with Idea of importing eggs from abroad but decided against – reason – not sure about the welfare of donors. Concerned about exploitation overseas.  Youth is what makes a good donor. Also proven fertility, and third motivation. Most have a back story, ‘hardly anyone does it for the £750. They are altruistic”. Mostly young mums and not motivated by money  Does not like the idea of egotistical donors – but even then, wouldn’t necessarily say no.  They do a bit of known donation, but they are not sure about this now  Nurses and embryologists do the matching. If parents want lots of info send them to US clinic. Those that don’t go to Spain. Parents want to know at least 2 things – are donors healthy, does donor look like me?  Thinks motivations are mostly altruistic  Use short antagonist protocol with agonist trigger – has almost eliminated OHSS. But this does mean some clinics are more aggressive because they can get more eggs – 20 without risk of OHSS.  TX is improved and safer for donors. Has improved donor welfare – better care and better counselling. Not sure that counselling should be compulsory.  Interested in expanded carrier screening for donors – but too expensive here at the moment. It’s a ‘risk reduction strategy’.  In favour of improving amount of screening of donors and more info on education, employment, psych profile, family history, photos – more like the US model. Couples should have the option to have this if desired – but not be charged for it.  We should have both options of donors – identifiable and anonymous as in US  Not always happy telling people they should disclose (minority ethnic eg).  Should have ED on the NHS.  Should be some changes on rules of moving gametes abroad.  More public info on difficulties for older women who needs ED – less public sympathy – should raise the profile.  Thinks we should triple compensation. $4000 is fare fee. Not price per egg, or more for selection criteria, but just more for all. Women “have autonomy and can make their own decisions”. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF9 UK**  **Nov 2018** |
| Job role | PR consultant |
| Organisation | PR company working with fertility clinics |
| Public/Private/Both | Private |
| Interviewer initials | NH |
| **Interview summary** | Company assisting marketing for IVF clinic since 2003  Work on campaigns to raise awareness of IVF. Helped with recruitment campaign for donors ‘to encourage altruistic donation’. Used press etc to raise issue of waiting list for donors for e.g. early menopause which was successful. More recently have done a strategy for recruiting egg sharers, subsequent to the reduction in NHS funding.  Use local media and social media/Facebook.  Use a ‘soft approach’. Use patient stories etc. Use human interest stories – case studies, focus groups. Use interactive games online, posters, cinema and TV broadcast  Keen to note their success  Discusses influence of donors partner, particularly for egg sharers – partners.  Also knowing someone struggling to conceive. They ‘used that’ to offer free treatment for friends and family if man donated his sperm to the sperm bank. He could nominate someone for free IVF.  Egg donors – free treatment is a big motivation. But you also need a ‘special kind of person.  Some are ‘purely altruistic’ (e.g some women who cant carry a baby themselves). Others doing it for a friend.  For egg sharers it’s “a mixture of economics and altruism”  Involved in recruiting egg sharers  They get stuff checked out with the HFEA to avoid contravening rules and check facts for their ‘messages’. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF10 UK**  **Jan 2019** |
| Job role | Director |
| Organisation | Surrogacy organization UK |
| Public/Private/Both | Private |
| Interviewer initials | NH |
| **Interview summary** | Works to enable surrogacy in UK. Matches surrogates with IPs. Also to facilitate overseas surrogacy and to campaign for legal change in UK  Main focus is really on IPs (intending parents) – providing info, discussing process, legal advice etc. provide the options for finding a donor and helping inform EDs that IP might have in mind. Particularly help IP who go to US where choice of donors is vast and more info available. Explain anonymity rules here and overseas. Seems to suggest that they signpost to [agency] if IP wants more info or connection. Also signpost to DCN. Do not themselves recruit ED. They thought at first they would, but now not needed – other agencies do it and not so much of a shortage now in any case.  Money not a huge incentive for donors in UK.  Discuss surrogate recruitment – difficult because of 2 year commitment. They screen surrogates and they match with IP  Suggests lots of known donors brought by IPs but also use [agency] and for those going to US provide info**.**  Discusses IP wishes about matching mainly – variable. Some looking for similarity (hetero couples) – gay dads sometimes to ‘improve’ on deficiencies , sometimes similar to non-bio dad. Some want relative, others repelled by that idea. Some who look at US get ‘super-picky’. Some bring known donor and agency provides info. and explanation of process.  Clinics like people referred or who use this agency as they have good reputation for checks, selection of surrogates, support , info etc. though this costs and they are more costly that the self-matching organizations.  In favour generally of more information for IPs  A lot is now happening outside the regulations and also things are moving fast eg DNA testing etc. which makes some redundant almost. there will be no such thing as an unknown donor.  They recommend [agency] who provide as much as legally possible in UK  If IPs take embryos made in the UK with UK donors abroad – ceases to be identifiable as not on HFEA register. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF11 UK**  **Jan 2019** |
| Job role | Director |
| Organisation | Online connection website |
| Public/Private/Both | Private |
| Interviewer initials | NH |
| **Interview summary** | Online website started in 2009 – origin in LGBT community and still advertise mainly there. Probably this is the main clientele but others not excluded. This is a connection service - people pay for message credits and they have charges for professionals to advertise themselves too. Encourage donors and recipients to meet. They load up profiles for don and recip and then if they want to contact each other they have to use the internal messaging system.(at a cost).  More sperm than egg donors, but a lot on the books or registered to date – not sure what that means – ie inactive accounts not known. Donors register themselves. Seems like they then go to clinics as known donors.  ED are women who want to know where their eggs are going. And match with recips who want to know where they come from. Suggestion that donors may want exclusive donation (re sperm) though no guarantee. Some want to co-parent.  DIY matching via the website initially and then they meet. They also have an online ‘personality test’ (4 items) that donors ad recipients can use.  Relationship with clinics can be a bit problematic. Accuses some of poaching donors. Also charge too much for known donation. – not clear though that any clinics refuse to treat.  Little discussion of donor motivation – other than help create families.  Not a fan of egg sharing/banking, because in favour more of one to one and known.  Argues: HFEA should change regulations to allow all identifiable at point of tx. Which would allow more one donor -one recip. Also clinics should charge less for known donors than at present. Would like clinics to be able to be register on their website and contact egg donors. Also thinks clinics should allow fresh sperm.  Communication is important . encourage meeting. Egg donors either want no contact; birthday card contact, or aunty figure contact. Some co-parenting also on the site. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF12 UK**  **July 2019** |
| Job role | Head of nursing and quality manager |
| Organisation | Fertility clinic |
| Public/Private/Both | Private |
| Interviewer initials | NH |
| **Interview summary** | Works in a large private clinic which has their own egg bank and successful egg donation programme.  Egg bank was created after having a higher number of donors than recipients and the clinic did not want to turn donors away. Donors were therefore given a chance to donate and freeze their eggs, which would be offered to future recipients.  Either fresh or frozen eggs are offered to recipients depending on availability and if recipients want to get matched straight away.  Clinic works with an agency to recruit donors, but they also recruit through their own marketing, website and social media.  Donors are preferably between 18-35 and free of any hereditary or genetic conditions, non-smokers, have a healthy BMI and no medical history. Clinic has a high refusal rate.  Thinks that the main motivations for donors are the will to help others, particularly for women who have known family members or friends with fertility issues.  Believes that the amount of compensation received (750) is appropriate and if it was any higher than people might donate for the wrong reasons.  Donors are informed about how many eggs are collected after retrieval.  In order to match recipients and donors, recipients fill out a characteristic form and what they are looking for in a donor. A team of nurses and a doctor will then match the donor and recipient using this information.  Recognised the need to support egg donors, particularly given the rise of at-home genetic tests which mean they can be identified by any donor-conceived child/children.  Discussed the risks of egg donation which include infection or bleeding, however notes that these risks are very small. Donors are informed about the risks through a nurse consultation. Donors also receive counselling. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | PROF13 UK  July 2019 |
| Job role | Consultant |
| Organisation | Fertility clinic |
| Public/Private/Both | Private |
| Interviewer Initials | NH |
| **Interview summary** | Clinic offers all fertility services including gamete donation. Recruits egg donors directly and through an agency  Those that come through the agency tend to know more by the time they get to the clinic (and less likely to drop out) but the process is the same. Use the same template to go through everything they need to know, including a timeline, the HFEA requirements, protocol, information about identification etc. It's the same for all patients. For agency donors all the appointments on one day to make it more convenient.  Regardless if where they come from all donors must have mandatory counselling to consider the social and psychological impact and the future.  No egg sharing for ethical and practical reasons. Do offer known donation.  Run a 7 day a week service – flexibility for donors; direct access to staff  Donors should be younger than 35, have a good reserve. Screening tests should be clear – if they raise any issues they would be given support.  Use fresh and frozen eggs.  Donors are altruistic. Have some known donors doing it for cousins, sisters etc. But others say that they want to help others  They can withdraw consent up the point of transfer if they change their minds.  Positive about the role of the HFEA - sees the advantage of having protocols (guidelines) for everything and everyone.  One change could be that HFEA and clinics could work more to encourage people to come forward to donate. More people would consider donor egg treatment if they could find the right donor.  Compensation of £750 barely covers expenses –7 or 8 clinic visits which take a lot of time. They need to take time off work – 24 hours when they have sedation. £750 has not changed with inflation/cost of living.  Don’t import eggs from overseas. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF14 UK**  **September 2019** |
| Job role | Egg donor coordinator |
| Organisation | Large clinical group in Spain, UK satellite |
| Public/Private/Both | Private |
| Interviewer initials | CW |
| **Interview summary** | Small satellite clinic to larger Spain based clinical group; because of difference in legal practice, interviewee sees the UK clinic as rather independent.  They do egg donation and at first worked with [agencies]. For several months they have been building their own donor base for fresh cycles; don’t have the capacity for an egg bank; egg donation staff comprises 4 members; they don’t offer freeze and share or egg-sharing.  They were recruiting through agencies, now trying their own advertisement and recruitment; shift in who is coming forward: more black donors. They don’t know what brought about the change.  Offering information and counselling; small familiar team  Interviewee does the matching by phenotype first and foremost; all fresh cycles  Could still benefit from more BME donors  Altruistic; money too little for [city] living standards to be making a difference  Appears to be thorough and explicit risk counselling (bleeding, pierced bladder etc) ; many women don’t come back to screening and counselling after information session  Wouldn’t change anything about policy, but would raise compensation  Considered too low. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | PROF15 UK  December 2019 |
| Job role | Nurse |
| Organisation | NHS Fertility clinic |
| Public/Private/Both | Both |
| Interviewer Initials | NH |
| **Interview summary** | Clinic treats around 40% patients on a private basis and 60% through the NHS.  Recognised there is a shortage of donors and that patients are not prepared to stay on very long waiting lists, even if they are eligible for NHS funding. Clinic facilitates patients to go overseas. Also recognized an increase of older patients that want egg donation.  Responsibilities include making sure that the clinic are working within HFEA legislation and keeping an eye on updates.  Recruitment of donors occurs through social media, stands at universities and other public events. Social media attracts the most potential donors.  There is a high percentage of donors who are refused to be a donor often because of family medical history. All potential donors have counselling, where patients can also be refused if the counselling raises any issues.  Clinic provides donors 750 compensation. P15 believes this works well but is not sure if this amount if enough. There can be some flexibility depending on donors circumstances for example if they have to pay for childcare in order to undergo treatment.  Clinic prefers to use fresh eggs for treatment but if they had more egg donors, then using frozen eggs could be considered.  Discussed the difficulties that can arise with donor matching particularly if the recipient is from a minority ethnic background. For example some Asian patients will accept eggs from a Caucasian donor due to the lack of Asian donors.  Discussed the potential issues of genetic testing kits which may cause problems for clinics in the future where donor-conceived children are able to track down the egg donor. |